CHRISTIAN COUNSELING ASSOCIATES

INTAKE FORM - CLIENT INFORMATION

Primary Client _____
Last Name First Name MI Nickname

Address _____
Street City State Zip

Home Phone _____ Work _____ Cell _____
Email _____
Date of Birth _____ Age _____ Gender _____
Occupation _____

May we call you at your home? _____ Yes _____ No
May we call you at your office? _____ Yes _____ No
May we call you on your cell? _____ Yes _____ No
May we leave a message at your home? _____ Office? _____ Cell? _____

Current Marital Status:
___ Never Married ___ Married ___ Engaged ___ Divorced ___ Separated ___ Widowed

Name of Spouse (if applicable) or Parents (if client is a minor) _____
Date of Marriage _____

Name of other family members:
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____

Your Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____
Spouse's Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____

Previous Marital History (if applicable):
SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPOUSE:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL INFORMATION

Are you currently attending a church? ____ Yes ____ No
If yes, what is the name of the church? _____
What is the denomination of the church? _____
Do you have a personal relationship with Christ? ____ Yes ____ No ____ Unsure
Are religious or spiritual issues important in your life? ____ Yes ____ No
Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ____ Yes ____ No
If yes, what are they? _____
Would you like prayer as part of your counseling? ____ Yes ____ No
Who referred you to our center? _____
May we contact them? ____ Yes ____ No
How would you rate your health? _____
How many hours do you sleep each night? _____
How would you rate your diet?
___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor
Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions
___ Sex ___ Pornography ___ Gambling ___ Gaming ___ Other: _____
Has your appetite or weight changed lately? _____
Are you currently on medication? ____ Yes ____ No If so, please complete the following:

Medication	Dosage	Physician	Purpose

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience.
_____
_____
How much are you troubled by this?
____ Constantly ____ Often ____ Somewhat ____ Not Very Much
Comments concerning this problem: _____
_____
Have you been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
3. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless. ____ Never ____ Rarely ____ Sometimes ____ Frequently
2. I am lonely. ____ Never ____ Rarely ____ Sometimes ____ Frequently
3. No one cares about me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
4. I am a failure. ____ Never ____ Rarely ____ Sometimes ____ Frequently
5. Most people don't like me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
6. I want to die. ____ Never ____ Rarely ____ Sometimes ____ Frequently
7. I want to hurt someone. ____ Never ____ Rarely ____ Sometimes ____ Frequently
8. I am so stupid. ____ Never ____ Rarely ____ Sometimes ____ Frequently
9. I am going crazy. ____ Never ____ Rarely ____ Sometimes ____ Frequently
10. I can't concentrate. ____ Never ____ Rarely ____ Sometimes ____ Frequently
11. I am so depressed. ____ Never ____ Rarely ____ Sometimes ____ Frequently
12. God is disappointed in me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
13. I can't be forgiven. ____ Never ____ Rarely ____ Sometimes ____ Frequently
14. Why am I so different? ____ Never ____ Rarely ____ Sometimes ____ Frequently
15. I can't do anything right. ____ Never ____ Rarely ____ Sometimes ____ Frequently
16. People hear my thoughts. ____ Never ____ Rarely ____ Sometimes ____ Frequently
17. I have no emotions. ____ Never ____ Rarely ____ Sometimes ____ Frequently
18. Someone is watching me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
19. I hear voices in my head. ____ Never ____ Rarely ____ Sometimes ____ Frequently
20. I am out of control. ____ Never ____ Rarely ____ Sometimes ____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Excessive anger, easily frustrated	____	Hyperactivity	____
Mood swings (depression-manic)	____	Change or loss of friends	____
Excessive guilt or shame	____	Sexual problems	____
Loss of energy	____	Self-mutilation, cutting	____
Loss of interest in activities	____	Excessive stress	____
Suicidal thoughts	____	Anxiety or excessive fears	____
Suicide attempts (how many)	____	Learning disabilities	____
Lying	____	Work or school related problems	____
Manipulation	____	Hallucinations, delusions, thought distortions	____
Poor impulse control	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name _____
Address _____
Home Phone _____ Cell Phone _____

For office use:
Therapist: _____
Diagnostic code: _____
Date of first session: _____ fee _____
Insurance Carrier: _____ Y or N